DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	R-C 08/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid third revisit survey to the abbreviated survey ending 3/31/16 and first revisit survey ending 5/12/16 and the second revisit ending 6/30/16, was conducted on 8/2/16 through 8/3/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. Two complaints were investigated during this survey. The census in this 190 certified bed facility was 167 at the time of the survey. The survey sample consisted of 16 current record reviews (Resident #301 through #316).	{F 000}	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under State and Federal Law. This Plan of Correction serves as the Facility's allegation of substantial compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	F157 1. The Physician has been notified that resident #311 did not receive medications as ordered. The Physician has been notified of resident # 312 refusal of medication. No adverse reactions were noted due to the medication variance.	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator/Executive Director 8.19.16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility document review it was determined that the facility staff failed to notify the physician for changes in the medication condition for two of 16 residents in the survey sample, Residents #311 and #312. 1. The facility staff failed to notify the physician when medications were not administered per the physician order for Resident # 311. 2. The facility staff failed to notify the physician when Resident # 312 refused his medications. The findings include: 1. Resident # 311 was admitted to the facility on 9/27/13 with a readmission on 11/20/13 with diagnoses that included but not limited to: diabetes mellitus (1), hypertension (2), cerebral vascular accident (3), low iron and sacral fracture (4). The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment	F 157	2. Residents that reside in this facility have the potential to be affected by this deficient practice. The physician has been notified for residents who did not receive medications as ordered. There have been no adverse effects to residents identified. 3. Licensed Nursing staff has been educated on following Physician orders for medication administration, notifying the Physician for medication refusal and any significant changes. Licensed Nursing staff has also completed a medication administration course. MARs/TARs will be audited daily x3 months then weekly x 3months by DCS/designee to ensure that medications are being administered as per Physician orders and any refusals have been reported to the Physician.	

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reference date) of 5/25/16 coded Resident # 311 coded the resident as scoring a 10 (ten) on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 (ten) being moderately impaired of cognition. Resident # 311 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician Order Sheet) dated 08/01/16 through 08/31/16 for resident # 311 documented:

- "Humalog (5). Inject 5 (five) units subcutaneously (under the skin) three times daily for DM (diabetes mellitus) at breakfast, lunch and dinner - Hold of blood sugar < (less than) 140. 9a.m. Start 12/26/15."

- "Lantus (6). Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."

The MAR (medication administration record) dated July 1016 for Resident # 311 documented:

- "Humalog. Inject 5 (five) units subcutaneously (under the skin) three times daily for DM (diabetes mellitus) at breakfast, lunch and dinner - Hold of blood sugar < (less than) 140. Start 12/26/15."

- "Lantus. Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."

The MAR evidenced missing documentation for the administration of Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. and Humalog on 7/28/16 at 7:30 a.m. and 11:30 a.m.; 7/29/16 at 7:30 a.m., 11:30 a.m. and 4:30 p.m. Further review of the MAR revealed that there was no documentation on the reverse of the MAR of notifying the physician. Review of the nurse's notes did not reveal any notification to the

4. Results of this review will be discussed by the administrator /designee at the Quality Assurance Performance Improvement meeting monthly for three months and then quarterly. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.
5. 8-22-16

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physician.

The MAR (medication administration record) dated August 2016 for Resident # 311 documented:
· "Lantus. Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."
The MAR evidenced missing documentation for the administration of Lantus on: 8/1/16 at 9:00 p.m. Further review of the MAR revealed that there was no documentation on the reverse of the MAR of notifying the physician. Review of the nurse's notes did not reveal any notification to the physician.

On 8/2/16 at 4:15 p.m. an interview was conducted with LPN (licensed practical nurse) # 12, charge nurse. LPN # 12 was asked to review the July and August MARs for Resident # 311. After reviewing the MARs LPN #12 was asked about the missing documentation on the MARs for the administration of Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. and Humalog on 7/28/16 at 7:30 a.m. and 11:30 a.m.; 7/29/16 at 7:30 a.m., 11:30 a.m. and 4:30 p.m. and Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. LPN # 12 stated, "If it not documented it wasn't done/administered." When asked if the physician should have been notified that Resident # 311's insulin was not administered LPN # 12 stated, "The physician should have been notified." When asked about the process of checking the MAR for missing documentation LPN # 12 stated, "The MAR is checked by administration and/or the charge nurse every day for holes and accuracy. The eleven to seven or seven to three shift should have picked up the missing documentation and notified the physician. When asked who was to

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administer Resident # 311's Lantus on 8/1/16 at 9:00 p.m. LPN # 12 stated, "(LPN # 13)."

On 8/2/16 at 4:15 p.m. an interview was conducted with LPN # 13 regarding the missing documentation on the August MAR for Resident # 311. When asked if she was the nurse for Resident # 311 on 8/1/16 during the 3:00 p.m. to 11:00 p.m. shift LPN # 13 stated, "Yes." LPN # 13 was then asked to review the August MAR for Resident # 311 and was asked if Lantus was administered to Resident # 311 at 9:00 p.m. on 8/1/16. LPN # 13 stated, "No, I don't think I gave it. I didn't know it until you pointed it out." When asked about notifying the physician that Resident # 311 didn't receive the Lantus LPN # 13 stated, "Should have notified the physician."

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. "Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient."

On 8/3/16 at 2:20 p.m. ASM (administrative staff member) # 1, the executive director, ASM # 2, the director of clinical services and ASM # 3, the regional director of clinical services was made aware of the findings.

No further information was obtained prior to exit.

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References:
(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm>.

(3) A stroke. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/000726.htm>.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(4) Located at the base of your spine. This information was obtained from the website: <https://medlineplus.gov/ency/patientinstructions/000610.htm>.

(5) Humalog (lispro) insulin is used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a697021.html>.

(6) Lantus (glargine) insulin is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website:

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https://medlineplus.gov/druginfo/meds/a600027.html.

2. Resident # 312 was admitted to the facility on 1/15/16 with a readmission on 5/16/16 with diagnoses that included but not limited to: glaucoma (1), skin cancer, coronary artery disease (2), Parkinson ' s disease (3), hyperlipidemia (4), pain, enlarged prostate (5), and hypothyroidism (6).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/23/16 coded Resident # 312 coded the resident as scoring a 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 being moderately impaired of cognition. Resident # 312 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician Order Sheet) dated 08/01/16 through 08/31/16 for resident # 312 documented:
- "Allopurinol (7). 100MG (milligrams). Take two every day. 9a.m. (9:00 a.m.). Start 05/17/16."
- "Clopidogrel Bisulfate (8). 75MG. Take one tab (tablet) every day. 9a.m. Start 05/17/16."
- "Finasteride (9). 5MG. Take 1(one) tab every day. 9a.m. Start 05/17/16."
- "Tamsulosin (10). 0.4MG. Take 1 (one) cap (caplet) by mouth every day. 9a.m. Start 05/17/16."
- "Vitamin B-12 (11). 500MCG (microgram). Take 1(one) tab by mouth every day. 9a.m. Start 05/17/16."
- "Calcium Carbonate. (12). 600MG. Take 1(one) tab by mouth twice a day. 9a.m. and 5p.m. (5:00 p.m.) Start 05/17/16."
- "Furosemide (13). 20MG. Take 1(one) tab

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by mouth twice a day. 9a.m. and 5p.m. Start 05/17/16."
- "Senexon (14). 8.6MG. Take 1(one) tab by mouth twice a day. 9a.m. and 5p.m. Start 05/17/16."
- "Carbidopa-Levodopa (15). 25MG-100MG. Take 3(three) tab by mouth three a day. 9a.m., 5p.m., 9p.m. (9:00 p.m.). Start 05/17/16."
- "Atorvastatin (16). 10MG. Take 1(one) tab by mouth at bedtime. 9p.m. Start 05/17/16."
- "Quetiapine Fumarate (17). 25MG. Take 1(one) tab by mouth at bedtime. 9p.m. Start 05/17/16."

The MAR dated July 2016 for Resident # 312 documented:
- "Allopurinol (7). 100MG (milligrams). Take two every day. 9a.m. (9:00 a.m.). Start 05/17/16."
- "Clopidogrel Bisulfate (8). 75MG. Take one tab (tablet) every day. 9a.m. Start 05/17/16."
- "Finasteride (9). 5MG. Take 1(one) tab every day. 9a.m. Start 05/17/16."
- "Tamsulosin (10). 0.4MG. Take 1 (one) cap (caplet) by mouth every day. 9a.m. Start 05/17/16."
- "Vitamin B-12 (11). 500MCG (microgram). Take 1(one) tab by mouth every day. 9a.m. Start 05/17/16."
- "Calcium Carbonate. (12). 600MG. Take 1(one) tab by mouth twice a day. 9a.m. and 5p.m. (5:00 p.m.) Start 05/17/16."
- "Furosemide (13). 20MG. Take 1(one) tab by mouth twice a day. 9a.m. and 5p.m. Start 05/17/16."
- "Senexon (14). 8.6MG. Take 1(one) tab by mouth twice a day. 9a.m. and 5p.m. Start 05/17/16."
- "Carbidopa-Levodopa (15). 25MG-100MG. Take 3(three) tab by mouth three a day. 9a.m.,

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5p.m., 9p.m. (9:00 p.m.). Start 05/17/16."
- "Atorvastatin (16). 10MG. Take 1(one) tab by mouth at bedtime. 9p.m. Start 05/17/16."
- " Quetiapine Fumarate (17). 25MG. Take 1(one) tab by mouth at bedtime. 9p.m. Start 05/17/16."

The July 2016 MAR for Resident # 312 evidenced the nurse's initials circled for the administration of:
- Allopurinol on 7/28/16 at 9a.m.
- Clopidogrel Bisulfate on 7/28/16 at 9a.m.
- Finasteride on 7/28/16 at 9a.m.
- Tamsulosin on 7/28/16 at 9a.m.
- Vitamin B-12 on 7/28/16 at 9a.m.
- Calcium Carbonate on 7/28/16 at 9a.m. and 5p.m.; 7/31/16 at 5p.m.
- Furosemide on 7/28/16 at 9a.m. and 5p.m.; 7/31/16 at 5p.m.
- Senexon on 7/28/16 at 9a.m. and 5p.m.; 7/31/16 at 5p.m.
- Carbidopa-Levodopa on 7/28/16 at 9a.m. and 9p.m; 7/29/16 and 7/31/16 at 9p.m.; 7/31/16 at 5p.m.
- Atorvastatin on 7/31/16 at 9p.m.
- Quetiapine Fumarate on 7/31/16 at 9p.m.

Further review of the MAR failed to evidence documentation on the back of the MAR that the physician was notified of Resident # 312's refusal of medications. The review of the nurse's notes did not reveal any notification to the physician.

On 8/3/16 at 9:45 a.m. an interview was conducted with RN (registered nurse) # 1, unit manager. When asked about nurse's initials being circled on the MAR RN # 1 stated, "It means the person refused the meds (medication), they were held or the person wasn't in the building. The reason is documented on the

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back of the MAR. The physician is notified and it is documented in the nurse's notes." RN # 1 was then asked to review the MAR dated June 2016 and nurse ' s notes dated 71/16 through 7/31/16 for Resident # 312. RN # 1 acknowledged Resident # 312 refused the medications on 7/28/16, 7/29/16 and 7/31/16. RN # 1 further stated that there was no documentation that the physician was notified of Resident # 312's refusal of medications.

On 8/3/16 at 2:20 p.m. ASM (administrative staff member) # 1, the executive director, ASM # 2, the director of clinical services and ASM # 3, the regional director of clinical services was made aware of the findings.

No further information was obtained prior to exit.

References:

(1) A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.html.

(2) A common type of heart disease. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html>.

(3) Type of movement disorder. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html>.

(4) High cholesterol. This information was

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obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

(5) Enlarged prostate (benign prostatic hyperplasia) the prostate is a gland in men. It helps make semen, the fluid that contains sperm. The prostate surrounds the tube that carries urine out of the body. This information was obtained from the website: <https://medlineplus.gov/enlargedprostatebph.html>.

(6) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.

(7) Used to treat gout. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a682673.html>.

(8) Used to prevent serious or life-threatening problems with the heart and blood vessels in people who have had a stroke, heart attack, or severe chest pain. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a601040.html>.

(9) Used to treat benign prostatic hypertrophy (BPH; enlargement of the prostate gland). This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a698016.html>.

(10) Used in men to treat the symptoms of an enlarged prostate (benign prostatic hyperplasia or

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BPH) This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a698012.html>.

(11) Helps in the formation of red blood cells and in the maintenance of the central nervous system. This information was obtained from the website: <https://medlineplus.gov/ency/article/002403.htm>.

(12) A dietary supplement used when the amount of calcium taken in the diet is not enough. Calcium is needed by the body for healthy bones, muscles, nervous system, and heart. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a601032.html>.

(13) Used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a682858.html>.

(14) Senexon (Senna) used on a short-term basis to treat constipation This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a601112.html>.

(15) Used to treat the symptoms of Parkinson's disease and Parkinson's-like symptoms This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a601068.html>.

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F 157	Continued From page 12 (16) Used to decrease the amount of fatty substances such as low-density lipoprotein (LDL) cholesterol ('bad cholesterol') and triglycerides in the blood and to increase the amount of high-density lipoprotein (HDL) cholesterol ('good cholesterol') in the blood. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a600045.html>? (17) Used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html.	F 157		
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to follow professional standards of practice for one of 16 residents in the survey sample; Resident #314.	{F 281}	F281 1. The order for blood pressure checks for resident #314 has been discontinued as per Physicians original order. 2. Residents that reside in this facility have the potential to be affected by this deficient practice. A review of Physician orders for the last thirty days has	

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The facility staff transcribed an order that had already been discontinued on 7/26/16, onto the August 2016 POS (Physician Order Sheet) and onto the August 2016 MAR (Medication Administration Record) for Resident #314.
The findings include:
Resident #314 was admitted to the facility on 4/17/15 with diagnoses that included but were not limited to osteoarthritis, diabetes mellitus type 2, chronic pain syndrome, high blood pressure, Alzheimer's disease, and unspecified dementia.
Resident #314's most recent Minimum Data Set (MDS) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/1/16.
Resident #314 was coded as being severely impaired in cognition, scoring three out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #314 was coded as requiring supervision with most ADLS (Activities of Daily Living) and extensive assistance with bathing.
Review of Resident #314's physician orders revealed the following order dated 7/19/16: "Check BP (Blood Pressure) daily x (times) one week. Call if SBP (Systolic Blood Pressure) is greater than 150." This order was initiated on 7/19/16 and stopped a week later per physician order, on 7/26/16.
Review of the August 2016 POS (Physician Order Sheet), not yet signed by the physician, but signed by a nurse on the unit, revealed a hand written order that documented the following: "Check BP (Blood Pressure) Daily Call MD (Medical Doctor) if SBP greater than 150." This order was supposed to be discontinued on 7/26/16, and was put back on the August POS (Physician Order Sheet).
Review of the August 2016 MAR (Medication Administration Record) revealed the following order: "7/19/16, Check BP q shift, Notify the MD

not revealed any additional transcription errors.
3. Licensed Nursing staff has been educated on proper transcription of Physician orders. DCS/designee will validate proper transcription of Physician orders by checking the MARs/TARs daily x3 months then weekly x 3 months.
4. Results of this review will be discussed by the administrator /designee at the Quality Assurance Performance Improvement meeting monthly for three months and quarterly thereafter. The committee will recommend provisions to the plan as indicated to sustain substantial compliance
5. 8-22-16

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of SBP greater than 150." Review of the MAR revealed that Resident #314's blood pressure was checked on 8/1/16 3-11 shift and 8/2/16 on 11-7 shift.

On 8/3/16 at 11:16 a.m., an interview was conducted with RN (Registered Nurse) # 1, the unit manager. When asked how long Resident #314's blood pressure was supposed to be monitored, RN #1 stated, "Should have been for one week." RN #1 stated it was a transcription error and the order for the blood pressure should not have been placed on the August 2016 POS or MAR. When asked who was responsible for transcribing orders, RN #1 stated, "The nurses or unit managers. The nurse who transcribed this is not working today."

On 8/3/16 at 11:30 a.m., an interview was attempted with the nurse who transcribed the order. She could not be reached for an interview.

On 8/3/16 at 11:35 a.m., an interview was conducted with ASM (Administrative Staff Member) # 4, the Regional Director of Clinical Services. ASM #4 stated that it looked like a transcription issue.

On 8/3/16 at 12:05 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #11. When asked who was responsible for transcribing orders, LPN # 11 stated that usually the unit managers will do it but sometimes nurses will transcribe. When asked the process of transcribing orders, LPN #11 stated that nurses would look at the physician orders and the previous POS and then transcribe active orders to the new POS and new MAR. LPN #11 stated that 11-7 shift nurses also check the MARS and TARS (Treatment Administration Record) during the month change over for errors.

On 8/3/16 at 2:35 p.m., ASM #1, the Executive Director, ASM #2, the Director of Clinical

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{F 281}	Continued From page 15 Services, ASM #3, the Assistant Director of Clinical Services, and ASM #4, the Regional Director of Clinical Services were made aware of the above findings. The facility policy titled, "Physician Orders," did not address transcribing orders from month to month. No further information was presented prior to exit. According to "Fundamentals of Nursing" 7th edition, 2009, Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 336, "The physician or health care provider should write all orders. The nurse is responsible for transcribing correctly written orders. If a verbal order is necessary (e.g. during an emergency), have it written and signed by the physician or health care provider as soon as possible, usually within 24 hours."	{F 281}		
{F 282} SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide services in accordance with the written plan of care for three of 16 residents in the survey sample; Resident #316, #310, #311. 1. The facility staff failed to follow the plan of care and ensure Resident #316's abdominal binder was put into place on 7/31/16 and 8/2/16.	{F 282}	F282 1. Resident #316 is wearing his abdominal binder as ordered by Physician. For resident #310 the wander-guard is in place and being checked every shift as per Physician order. Resident #311 is receiving diabetic management as per Physician order. 2. Residents who have orders for abdominal binders, wander-guards, and Insulin have the potential to be affected. Observations have been completed for residents with abdominal binders and wander-guards and found to be in	

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{F 282}	Continued From page 16 2. The facility staff failed to follow the plan of care for the implementation of Resident # 310's wander guard. 3. The facility staff failed to follow Resident # 311's care plan for the administration of insulin, Humalog and Lantus. The findings include: 1a. Resident # 316 was admitted to the facility on 6/8/16 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), muscle weakness, heart failure, high blood pressure and chronic respiratory failure. Resident #316's most recent MDS (Minimum Data Set) was a five day scheduled assessment with an ARD (Assessment Reference Date) of 7/29/16. Resident #316's was coded as being severely cognitively impaired in the ability to make daily decisions scoring three on the staff assessment for mental status exam. Resident #316 was coded as requiring extensive assistance to being dependent on staff with ADLS (Activities of Daily Living). The resident was coded as having a peg tube. On 8/2/16 at 2:40 a.m., observation of Resident #316 was conducted. Two nursing aides, CNA (certified nursing assistant) #3 and CNA # 4 were in the room and had just finished changing him. When asked if the resident had a peg tube, CNA #3 and CNA #4 stated yes. When asked if Resident #316 had his abdominal binder in place, CNA #4 stated, "I am not sure let me check." She lifted up the Resident's shirt, just to expose his stomach and he did not have his abdominal binder in place. On 8/2/16 at 3:00 p.m., CNA #4 stated, "Apparently his abdominal binder has been in the laundry to be washed." CNA #4 could not	{F 282}	compliance. Medication observations are being conducted by the DCS/designee for currently employed licensed nurses. 3. Licensed Nursing staff has been educated on following Physician orders for medication administration, following treatment orders, and accurate and complete documentation. Licensed Nursing staff has also completed a medication administration course. MARs/TARs will be audited daily x3 months then weekly x 3 months by DCS/designee to ensure that medications are being administered as per Physician order and treatments have been executed as per Physician order, to include abdominal binders, wander-guards and insulin.	

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remember when it was brought to the laundry or how long the resident did not have his abdominal binder.
A physician order documented, "Abdominal Binder check placement and skin qs (every shift) and prn (as needed)..."
Review of Resident #316's care plan dated 6/22/16 documented the following intervention under care area ADLS (Activities of Daily Living) that was initiated on 7/22/16: "Abdominal Binder as ordered."
Review of the July 2016 MAR revealed that on July 30th and 31st 2016, the MAR was left blank for 7-3, 3-11 and 11-7 shift for the Abdominal binder order. Further Review of Resident #316's August 2016 TAR (treatment administration record) revealed that the order for the Abdominal binder had not been documented as administered at that time.

On 8/3/16 at 10:10 a.m., an interview was conducted with LPN #2, regarding the process followed when a resident has an order for an abdominal binder to be put into place but it needs to be washed. LPN #2 stated that something would have to be put into place while the abdominal binder was being washed. LPN #2 stated the resident should either have a second abdominal binder or he would ask the treatment nurse to put something in place to protect the resident's peg tube. LPN #2 stated that if there is an order for an abdominal binder and it is on the care plan than it should have been on. He stated he wasn't sure how long it usually took laundry to bring items like an abdominal binder back to the unit. When asked what was the purpose of the care plan, LPN #2 stated that it was a guideline on what is going on with the patient, what needs to be put into place and what is expected as an

4. Results of this review will be discussed by the administrator /designee at the Quality Assurance Performance Improvement meeting monthly for three months and then quarterly. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.
5. 8-22-16

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outcome. LPN #2 stated that all nurses and CNA's have access to the care plan.

On 8/3/16 at 10:35 a.m., an interview was conducted with LPN #4. She stated that she worked 11-7 shift on 8/1/16 to 8/2/16 and that the abdominal binder was in place. When asked what process is followed when a resident's abdominal binder needs to be washed, LPN #4 stated the resident should have two in case the one needs to be changed out. LPN #4 stated that if there is an order for an Abdominal Binder and it is on the care plan it should have been in place.

On 8/3/16 at 10:45 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #7, the nurse who worked the weekend on July 30th through the 31st 2016. When asked what blanks meant on the MAR she stated the nurse may have forgotten to sign the MAR or the treatment or medication was not administered. LPN #7 stated that she had worked on 7/30 and 7/31/16 7-3 and 3-11 shift. When asked if she had Resident #316, LPN #7 stated that she did. When asked if he had his abdominal binder in place, LPN #7 stated that she was not sure about Saturday but she knew on Sunday he did not have one in place. When asked why he did not have his abdominal binder in place, LPN #7 stated, "I didn't think we were putting it on him because he had a peg tube infection." When asked if she had documented anywhere that she did not place the binder on due to an infection, LPN #7 stated that she did not. When asked if there was an order to hold the abdominal binder until the infection healed, LPN #7 stated that she could not remember.

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On 8/3/16 at 11:50 a.m., an interview was conducted with LPN #8. She stated that had worked on August 1st 2016, on 11-7 shift. LPN #8 stated that the abdominal binder was in place during her shift. LPN #8 stated that if the abdominal binder had to be washed that she would refer to her DCS (Director of Clinical Services) or unit manager for directions. LPN #8 stated that she would probably put a towel or sheet to protect the resident's peg tube. LPN #8 stated that if the abdominal binder was on the care plan or there was an order than it should have been in place.

On 8/3/15 at 12:05 p.m., an interview was conducted with LPN #11. When asked what the purpose of the care plan was, LPN #11stated it was to let facility staff know, other than nurses, what is going on with the resident such as what interventions are put into place. When asked if a resident has an intervention on the care plan for an abdominal binder should an abdominal binder be in place, LPN #11 stated, "Yes it should be on the resident."

On 8/3/16 at 2:35 p.m., ASM #1, the Executive Director, ASM #2, the Director of Clinical Services, ASM #3, the Assistant Director of Clinical Services, and ASM #4, the Regional Director of Clinical Services were made aware of the above findings.

The facility policy titled, "Plans of Care" documents in part, the following: "Direct Care Staff should be aware, understand and follow their Resident's Plan of Care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his (sic) can be provided and plan of care changed if necessary. No further information was presented prior to exit.

According to Potter and Perry's, Fundamentals of

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Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions."

2. The facility staff failed to follow the plan of care for the implementation of Resident # 310's wander guard.

Resident # 310 was admitted to the facility on 11/20/15 with a readmission on 2/3/16 with diagnoses that included but not limited to: dementia with behaviors disturbances (1), schizophrenia (2), hypertension (3), cannabis dependence (4), cocaine dependence (5).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/20/16 coded Resident # 310 coded the resident as scoring a 4 (four) on the brief interview for mental status (BIMS) of a score of 0 - 15, 4 (four) being severely impaired of cognition. Resident # 310 was coded as requiring extensive assistance of one staff member for activities of daily living.

The physician's "Telephone Order" dated 7/29/16 documented, "7/29/16. Wander guard (check) placement Q (every) shift, 2. Wander guard (check) function 11p-3a (11:00 p.m. to 7:00 a.m.) shift"

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The "Behavior / Mood" care plan dated 4/1/2014 for Resident # 310 documented, "Approaches & Interventions: 7/29/16 Wander guard (check) placement QS (every shift); 7/29/16 Wander guard (check) function 11p-7a shift."

Resident # 310's TAR (treatment administration record) dated August 2016 was reviewed. The TAR documented,
- "Wander guard (check) placement QS. 7-3 (7:00 a.m.-3:00 p.m.), 3-11 (3:00 p.m.-11:00 p.m.), 11-7 (11:00 p.m.-7:00 a.m.)."
- "Check function of wander guard Q day."

The TAR was blank on 8/1/16.
The TAR failed to evidence documentation of the wander guard being checked each shift.

On 8/2/16 at 1:30 p.m. an interview was conducted with LPN (licensed practical nurse) # 12. When asked about blanks on a MAR (medication administration record) and TAR LPN # 12 stated, "If it's not documented it's not done or administered." After reviewing the TAR dated August 2016 for Resident # 310, LPN # 12 was asked about the missing documentation on the TAR for Resident # 310's wander guard. LPN # 12 stated, "It was not documented it wasn't done. I check the wander guard in at the beginning of the shift but today I didn't. It should be checked for placement every shift. Being the charge nurse it is something I should have done."

During another interview with LPN # 12 on 8/3/16 at 10:15 a.m. regarding a resident's care plan LPN # 12 stated, "The purpose of the care plan is to let you know the changes or progress of a person. Everything on the care plan should be done." After reviewing Resident # 310's TAR and

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care plan RN # 12 was asked if Resident # 310's care plan was followed for checking the wander guard. LPN # 12 stated, "No."

The facility's policy "Plans of Care" documented, "Direct care staff should be aware, understand and follow their Resident's Plan of Care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his [sic] can be provided and plan of care changed if necessary. "

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

On 8/3/16 at 2:20 p.m. ASM (administrative staff member) # 1, the executive director, ASM # 2, the director of clinical services, and ASM # 3, the regional director of clinical services was made aware of the findings.

No further information was obtained prior to exit.

References:

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(1) A group of symptoms caused by disorders that affect the brain) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/dementia.html>.

(2) A mental disorder that makes it hard to tell the difference between what is real and not real.) This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm.

(3) High blood pressure This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(4) Cannabis dependence (marijuana) is a green, brown, or gray mix of dried, crumbled parts from the marijuana plant. It can be rolled up and smoked like a cigarette or cigar or smoked in a pipe. Sometimes people mix it in food or inhale it using a vaporizer. This information was obtained from the website: <https://medlineplus.gov/marijuana.html>.

(5) A white powder. It can be snorted up the nose or mixed with water and injected with a needle. Cocaine can also be made into small white rocks, called crack. Crack is smoked in a small glass pipe. Some of the most common serious problems include heart attack and stroke. You are also at risk for HIV/AIDS and hepatitis, from sharing needles or having unsafe sex. Cocaine is more dangerous when combined with other drugs or alcohol. This information was obtained from the website: https://medlineplus.gov/cocaine.html.

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3. Facility staff failed to follow Resident # 311's care plan for the administration of insulin, Humalog (1) and Lantus (2).

Resident # 311 was admitted to the facility on 9/27/13 with a readmission on 11/20/13 with diagnoses that included but not limited to: diabetes mellitus (3), hypertension (4), cerebral vascular accident (5), low iron and sacral fracture (6).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/25/16 coded Resident # 311 coded the resident as scoring a 10 (ten) on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 (ten) being moderately impaired of cognition. Resident # 311 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician Order Sheet) dated 08/01/16 through 08/31/16 for resident # 311 documented:
· " Humalog. Inject 5 (five) units subcutaneously (under the skin) three times daily for DM (diabetes mellitus) at breakfast, lunch and dinner - Hold of blood sugar < (less than) 140. 9a.m. Start 12/26/15."
· "Lantus. Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."

The MAR (medication administration record) dated July 1016 for Resident # 311 documented:
· "Humalog. Inject 5 (five) units subcutaneously (under the skin) three times daily for DM {diabetes mellitus) at breakfast, lunch and dinner - Hold of blood sugar < (less than) 140. Start 12/26/15."
· "Lantus. Inject 10 (ten) units subcutaneously

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at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."
The MAR evidenced missing documentation for the administration of Lantus on:
7/28/16 and 7/29/16 at 9:00 p.m. and Humalog on7/28/16 at 7:30 a.m. and 11:30 a.m.; 7/29/16 at 7:30 a.m., 11:30 a.m. and 4:30 p.m. Further review of the MAR revealed that there was no documentation on the reverse of the MAR of notifying the physician. Review of the nurse's notes did not reveal any notification to the physician.

The MAR (medication administration record) dated August 2016 for Resident # 311 documented:
· "Lantus. Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."
The MAR evidenced missing documentation for the administration of Lantus on:
8/1/16 at 9:00 p.m. Further review of the MAR revealed that there was no documentation on the reverse of the MAR of notifying the physician. Review of the nurse's notes did not reveal any notification to the physician.

The "Metabolic" care plan dated 4/1/2014 with a review date of 6/5/16 for Resident # 310 documented, "Focus: The Resident is at risk for Metabolic Complications. Etiologies (the cause): Diabetes." Under "Approaches & Interventions" it documented, "Medications as ordered."

On 8/3/16 at 10:10 a.m., an interview was conducted with LPN #2. When asked what was the purpose of the care plan he stated that it was a guideline on what is going on with the patient, what needs to be put into place and what is expected as an outcome. He stated that all

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nurses and CNA's (certified nursing assistants) have access to the care plan.

During an interview with LPN # 12 on 8/3/16 at 10:15 a.m. regarding a resident's care plan LPN # 12 stated, "The purpose of the care plan is to let you know the changes or progress of a person. Everything on the care plan should be done." After reviewing Resident # 31's MAR and care plan LPN # 12 was asked if Resident # 311's care plan was followed for the administration of insulin. LPN # 12 stated, "No."

On 8/3/15 at 12:05 p.m., an interview was conducted with LPN #11. When asked what was the purpose of the care plan she stated that it was to let facility staff know, other than nurses, what is going on with the resident such as what interventions are put into place.

On 8/3/16 at 2:20 p.m. ASM (administrative staff member) # 1, the executive director, ASM # 2, the director of clinical services and ASM # 3, the regional director of clinical services was made aware of the findings.

No further information was obtained prior to exit.

References:
(1) Humalog (lispro) insulin is used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a697021.html>.

(2) Lantus (glargine) insulin is also used to treat

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people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm>.

(4) High blood pressure. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/highbloodpressure.html>.

(5) A stroke. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/000726.htm>.

(6) Located at the base of your spine. This information was obtained from the website: <https://medlineplus.gov/ency/patientinstructions/000610.htm>.

{F 282}

{F 309} SS=E 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

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1. Resident #316 is wearing his abdominal binder as ordered by Physician. Resident #311 is receiving Insulin as per Physician

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain the highest level of well being for three of 16 residents in the survey sample; Resident #316, #311 and #310.
1. Facility staff failed to follow physician orders and ensure an abdominal binder was in place for Resident #316 on 7/31/16 on 7-3 and 3-11 shift and on 8/2/16.

2. The facility staff failed to follow Resident # 311's physician's orders for the administration of insulin.

3. The facility staff failed to ensure Resident # 310's wander guard was in place as ordered by the physician.

The findings include:

1. Resident # 316 was admitted to the facility on 6/8/16 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), muscle weakness, heart failure, high blood pressure and chronic respiratory failure. Resident #316's most recent MDS (Minimum Data Set) was a five day scheduled assessment with an ARD (Assessment Reference Date) of 7/29/16. Resident #316's was coded as being severely cognitively impaired in the ability to make daily decisions scoring three on the staff assessment for mental status exam. Resident #316 was coded as requiring extensive assistance to being dependent on staff with ADLS

order. For resident #310 the wander-guard is in place and being checked every shift as per Physician order.
2. Residents who have orders for abdominal binders, wander-guards, and Insulin have the potential to be affected. Observations have been completed for residents with abdominal binders and wander-guards and found to be in compliance. Medication observations are being conducted by the DCS/designee for currently employed licensed nurses to ensure medication administration.
3. Licensed Nursing staff has been educated on following Physician orders for medication administration, following treatment orders and accurate and complete documentation. Licensed Nursing staff has also completed a medication administration course.

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{F 309}	Continued From page 29 (Activities of Daily Living). The resident was coded as having a peg tube. On 8/2/16 at 2:40 a.m., observation of Resident #316 was conducted. Two nursing aides, CNA (certified nursing assistant) #3 and CNA # 4 were in the room and had just finished changing him. When asked if the resident had a peg tube, CNA #3 and CNA #4 stated yes. When asked if Resident #316 had his abdominal binder in place, CNA #4 stated, "I am not sure let me check." She lifted up the Resident's shirt, just to expose his stomach and he did not have his abdominal binder in place. On 8/2/16 at 3:00 p.m., CNA #4 stated, "Apparently his abdominal binder has been in the laundry to be washed." CNA #4 could not remember when it was brought to the laundry or how long the resident did not have his abdominal binder. A physician order documented, "Abdominal Binder check placement and skin qs (every shift) and prn (as needed)..." Review of Resident #316's care plan dated 6/22/16 documented the following intervention under care area ADLS (Activities of Daily Living) that was initiated on 7/22/16: "Abdominal Binder as ordered." Review of the July 2016 MAR revealed that on July 30th and 31st 2016, the MAR was left blank for 7-3, 3-11 and 11-7 shift for the Abdominal binder order. Further Review of Resident #316's August 2016 TAR (treatment administration record) revealed that the order for the Abdominal binder had not been documented as administered at that time. On 8/3/16 at 10:10 a.m., an interview was conducted with LPN #2, regarding the process	{F 309}	MARs/TARs will be audited daily x3 months then weekly x 3 months by DCS/designee to ensure that medications are being administered as per Physician order and treatments have been executed as per Physician order, to include abdominal binders, wander-guards and insulin. Random audits will be conducted for residents with orders for abdominal binders and wander-guards to ensure devices are in place 3x weekly for 1 month. Random medpass observations will be conducted 3x weekly for 1 month by DCS/designee. 4. Results of this review will be discussed by the administrator /designee at the Quality Assurance Performance Improvement meeting monthly for three months and then quarterly. The committee will recommend provisions to the plan as indicated to sustain substantial compliance 5. 8-22-16	

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followed when a resident has an order for an abdominal binder to be put into place but it needs to be washed. LPN #2 stated that something would have to be put into place while the abdominal binder was being washed. LPN #2 stated the resident should either have a second abdominal binder or he would ask the treatment nurse to put something in place to protect the resident's peg tube. LPN #2 stated that if there is an order for an abdominal binder and it is on the care plan than it should have been on. He stated he wasn't sure how long it usually took laundry to bring items like an abdominal binder back to the unit.

On 8/3/16 at 10:35 a.m., an interview was conducted with LPN #4. She stated that she worked 11-7 shift on 8/1/16 to 8/2/16 and that the abdominal binder was in place. When asked what process is followed when a resident's abdominal binder needs to be washed, LPN #4 stated the resident should have two in case the one needs to be changed out. LPN #4 stated that if there is an order for an Abdominal Binder and it is on the care plan it should have been in place.

On 8/3/16 at 10:45 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #7, the nurse who worked the weekend on July 30th through the 31st 2016. When asked what blanks meant on the MAR she stated the nurse may have forgotten to sign the MAR or the treatment or medication was not administered. LPN #7 stated that she had worked on 7/30 and 7/31/16 7-3 and 3-11 shift. When asked if she had Resident #316, LPN #7 stated that she did. When asked if he had his abdominal binder in place, LPN #7 stated that she was not sure about Saturday but she knew on Sunday he did

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not have one in place. When asked why he did not have his abdominal binder in place, LPN #7 stated, "I didn't think we were putting it on him because he had a peg tube infection." When asked if she had documented anywhere that she did not place the binder on due to an infection, LPN #7 stated that she did not. When asked if there was an order to hold the abdominal binder until the infection healed, LPN #7 stated that she could not remember.

On 8/3/16 at 11:50 a.m., an interview was conducted with LPN #8. She stated that had worked on August 1st 2016, on 11-7 shift. LPN #8 stated that the abdominal binder was in place during her shift. LPN #8 stated that if the abdominal binder had to be washed that she would refer to her DCS (Director of Clinical Services) or unit manager for directions. LPN #8 stated that she would probably put a towel or sheet to protect the resident's peg tube. LPN #8 stated that if the abdominal binder was on the care plan or there was an order than it should have been in place.

On 8/3/15 at 12:05 p.m., an interview was conducted with LPN #11. When asked if a resident has an order for an abdominal binder should an abdominal binder be in place, LPN #11 stated, "Yes it should be on the resident."

The facility policy titled, "Physician orders" did not address the above concern.

On 8/3/16 at 2:35 p.m., ASM #1, the Executive Director, ASM #2, the Director of Clinical Services, ASM #3, the Assistant Director of Clinical Services, and ASM #4, the Regional Director of Clinical Services were made aware of the above findings.

No further information was presented prior to exit.

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In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

2. The facility staff failed to follow Resident # 311's physician's orders for the administration of insulin.

Resident # 311 was admitted to the facility on 9/27/13 with a readmission on 11/20/13 with diagnoses that included but not limited to: diabetes mellitus (1), hypertension (2), cerebral vascular accident (3), low iron and sacral fracture (4).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/25/16 coded Resident # 311 as scoring a 10 out of 15 on the brief interview for mental status (BIMS), indicating the resident was moderately impaired of cognition. Resident # 311 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician Order Sheet) dated 08/01/16 through 08/31/16 for resident # 311 documented:
· "Humalog (5). Inject 5 (five) units subcutaneously (under the skin) three times daily for DM (diabetes mellitus) at breakfast, lunch and dinner - Hold if blood sugar < (less than) 140. 9a.m. Start 12/26/15."

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· "Lantus (6). Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."

The MAR (medication administration record) dated July 2016 for Resident # 311 documented:
· "Humalog. Inject 5 (five) units subcutaneously (under the skin) three times daily for DM (diabetes mellitus) at breakfast, lunch and dinner - Hold if blood sugar < (less than) 140. Start 12/26/15."

· "Lantus. Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."
The MAR evidenced missing documentation for the administration of Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. and Humalog on 7/28/16 at 7:30 a.m. and 11:30 a.m.; 7/29/16 at 7:30 a.m., 11:30 a.m. and 4:30 p.m. Further review of the MAR revealed that there was no documentation on the reverse side of the MAR evidencing notification to the physician. Review of the nurses' notes did not reveal any notification to the physician of Resident #311's insulin not being administered on the dates and times documented above.

The MAR (medication administration record) dated August 2016 for Resident # 311 documented:
· "Lantus. Inject 10 (ten) units subcutaneously at bedtime. 9p.m. (9:00 p.m.) Start 06/07/16."
The MAR evidenced missing documentation for the administration of Lantus on: 8/1/16 at 9:00 p.m. Further review of the MAR revealed that there was no documentation on the reverse side of the MAR for notification to the

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physician. Review of the nurse's notes did not reveal any notification to the physician of the insulin not being administered as ordered.

On 8/2/16 at 4:15 p.m. an interview was conducted with LPN (licensed practical nurse) # 12, charge nurse. LPN # 12 was asked to review the July and August 2016, MARs for Resident # 311. After reviewing the MARs LPN #12 was asked about the missing documentation on the MARs for the administration of Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. and Humalog on 7/28/16 at 7:30 a.m. and 11:30 a.m.; 7/29/16 at 7:30 a.m., 11:30 a.m. and 4:30 p.m. and Lantus on: 7/28/16 and 7/29/16 at 9:00 p.m. LPN # 12 stated, "If it not documented it wasn't done/administered." When asked if the physician should have been notified that Resident # 311's insulin was not administered, LPN # 12 stated, "The physician should have been notified." When asked about the process of checking the MAR for missing documentation, LPN # 12 stated, "The MAR is checked by administration and/or the charge nurse every day for holes and accuracy. The eleven to seven or seven to three shift should have picked up the missing documentation and notified the physician. When asked who was to administer Resident # 311's Lantus on 8/1/16 at 9:00 p.m., LPN # 12 stated, "(LPN # 13)."

On 8/2/16 at 4:15 p.m. an interview was conducted with LPN # 13 regarding the missing documentation on the August MAR for Resident # 311. When asked if she was the nurse for Resident # 311 on 8/1/16 during the 3:00 p.m. to 11:00 p.m. shift, LPN # 13 stated, "Yes." LPN # 13 was then asked to review the August MAR for Resident # 311 and was asked if Lantus was administered to Resident # 311 at 9:00 p.m. on

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8/1/16. LPN # 13 stated, "No, I don't think I gave it. I didn't know it until you pointed it out."

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. "The physician or health care provider is responsible for directing the medical treatment of a patient."

On 8/3/16 at 2:20 p.m. ASM (administrative staff member) # 1, the executive director, ASM # 2, the director of clinical services and ASM # 3, the regional director of clinical services was made aware of the findings.

No further information was obtained prior to exit.

References:
(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood). This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm>.

(3) A stroke. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/000726.htm>.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(4) Located at the base of your spine. This information was obtained from the website: <https://medlineplus.gov/ency/patientinstructions/

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000610.htm>.

(5) Humalog (lispro) insulin is used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: <https://medlineplus.gov/druginfo/meds/a697021.html>.

(6) Lantus (glargine) insulin is also used to treat people with type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood) who need insulin to control their diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a600027.html.

3. The facility staff failed to ensure Resident # 310's wander guard was in place as ordered by the physician.

Resident # 310 was admitted to the facility on 11/20/15 with a readmission on 2/3/16 with diagnoses that included but not limited to: dementia with behaviors disturbances (1), schizophrenia (2), hypertension (3), cannabis dependence (4), and cocaine dependence (5).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/20/16 coded Resident # 310 as scoring a 4 out of 15 on the brief interview for

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mental status (BIMS), indicating the resident was severely impaired of cognition. Resident # 310 was coded as requiring extensive assistance of one staff member for activities of daily living.

A FRI (facility reported incident) dated "07-29-2016" documented, "Resident Involved: (Resident # 310); Injuries: No." Under "Incident Type" it documented, "Resident Elopement." Under "Describe Incident, indicating location, and action taken" it documented, "(Resident # 310) has a diagnosis of muscle weakness, schizophrenia, dementia, with behavioral disturbances, and cognitive communication deficit. (Resident # 310) was let out of the building by staff at approximately 4:03 p.m. (Resident # 310) was seen at the curb by staff and brought back to the facility without any incidence, she was assessed and no injuries were noted. MD/RP (medical doctor/responsible party) were notified."

The nurse's note documented on the "Interdisciplinary Progress Notes" sheet dated 7/29/16 by LPN # 12 at 4:30 p.m. for Resident # 310 documented, "Resident went through the front doors today stating she was headed to (Name of Street). Resident was brought back into building by staff and skin checked over for any new areas in which did no injury occur [sic]. Resident has had a [sic] elopement eval (evaluation) performance and is a risk for elopement. Resident will be having a wander guard placed on her ankle for safety purposes. Resident will be monitored closely for (changes) in status and exit seeking behaviors. MD & (and) RP aware of wander guard being placed on. Message left for RP of info (information)."

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The facility's "Elopement Risk Evaluation" dated 2/29/16 for Resident # 310 documented, "Based on potential risk factors above, resident is determined to be AT RISK for elopement: No." The "Elopement Risk Evaluation" dated 7/29/16 for Resident # 310 documented, "Based on potential risk factors above, resident is determined to be AT RISK for elopement: Yes."

A physician's "Telephone Order" dated 7/29/16 documented, "7/29 1. Wander guard (check) placement Q (every) shift, 2. Wander guard (check) function 11p-3a (11:00 p.m. to 7:00 a.m.) shift."

The "Behavior / Mood" care plan dated 4/1/2014 for Resident # 310 documented, "Approaches & Interventions: 7/29/16 Wander guard (check) placement QS (every shift); 7/29/16 Wander guard (check) function 11p-7a shift."

Resident # 310's TAR (treatment administration record) dated August 2016 was reviewed. The TAR documented,
- "Wander guard (check) placement QS. 7-3 (7:00 a.m.-3:00 p.m.), 3-11 (3:00 p.m.-11:00 p.m.), 11-7 (11:00 p.m.-7:00 a.m.)."
- "Check function of wander guard Q day."

The TAR was blank on 8/1/16.
The TAR failed to evidence documentation of the wander guard being checked each shift.

On 8/2/16 at 1:30 p.m. an interview was conducted with LPN (licensed practical nurse) # 12. After reviewing the TAR dated August 2016 for Resident # 310, LPN # 12 was asked about the missing documentation on the TAR for Resident # 310's wander guard. LPN # 12 stated, "It was not documented it wasn't done. I check

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the wander guard in at the beginning of the shift but today I didn't. It should be checked for placement every shift. Being the charge nurse it is something I should have done."

On 8/2/16 at 1:40 p.m. an observation was conducted of Resident # 310. Resident # 310 was in her wheelchair, in her room propelling herself around the room. Further observation of Resident # 310 failed to evidence a wander guard on her person or on the wheelchair she was in.

On 8/2/16 at 1:45 p.m. an observation was conducted of Resident # 310 with LPN (licensed practical nurse) # 12, charge nurse. When asked about the wander guard for Resident # 310, LPN # 12 stated it was on Resident # 310's ankle. LPN # 12 was asked to lift the bottom of Resident # 310's pants on the right and left legs to observe Resident # 310's ankles. Upon lifting the bottom of Resident # 310's pants, LPN # 12 acknowledged the wander guard was not on Resident # 310. LPN # 12 further examined the wheelchair Resident # 310 was sitting and verified that the wander guard was not attached to the wheelchair either. LPN # 12 stated, "She (Resident # 310) had it on yesterday. I'll find out what happened to it."

On 8/2/16 at 2:20 p.m. an interview was conducted with CNA (certified nursing assistant) # 1 in the presence of LPN # 12, charge nurse. CNA # 1 showed this surveyor Resident # 310's wander guard. CNA # 1 stated that while changing Resident # 310 she found the wander guard for Resident # 310 in the dresser drawer. CNA # 1 and LPN # 12 stated Resident # 310 did

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not have the wander guard on. LPN # 12 further stated, "I don't know how it came off." An examination of the wander guard band with LPN # 12 revealed that the band was still fastened together and intact. LPN # 12 stated, "We'll have to get a new band."

On 8/2/16 at 2:55 p.m. an observation of Resident # 310 revealed she was in her wheelchair self propelling herself in the hallway around the nurse's station. The wander guard was on Resident # 310's wrist and she was displaying it as a watch showing this surveyor and facility staff.

On 8/3/16 at 2:20 p.m. ASM (administrative staff member) # 1, the executive director, ASM # 2, the director of clinical services, and ASM # 3, the regional director of clinical services was made aware of the findings.

No further information was obtained prior to exit.

References:

(1) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

(2) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm.

(3) High blood pressure. This information was

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{F 309}	Continued From page 41 obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) Cannabis dependence (marijuana) is a green, brown, or gray mix of dried, crumbled parts from the marijuana plant. It can be rolled up and smoked like a cigarette or cigar or smoked in a pipe. Sometimes people mix it in food or inhale it using a vaporizer. This information was obtained from the website: https://medlineplus.gov/marijuana.html. (5) A white powder. It can be snorted up the nose or mixed with water and injected with a needle. Cocaine can also be made into small white rocks, called crack. Crack is smoked in a small glass pipe. Some of the most common serious problems include heart attack and stroke. You are also at risk for HIV/AIDS and hepatitis, from sharing needles or having unsafe sex. Cocaine is more dangerous when combined with other drugs or alcohol. This information was obtained from the website: https://medlineplus.gov/cocaine.html.	{F 309}	F 329 1. Resident #309 is being provided non-pharmacological interventions. There is documentation to support the effectiveness of Xanax. 2. Residents that reside in the facility have the potential to be affected. A review of residents receiving PRN psychotropics medications has been conducted to ensure non-pharmacological interventions have been provided prior to administration. A review of medication effectiveness has also been conducted. 3. In-servicing has been provided to the licensed nurses by the DCS/designee regarding behavior management program to include non-pharmacological interventions prior to medication administration,	
{F 329} SS=D	Z 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	{F 329}		

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{F 329}	Continued From page 42 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure one of 16 residents was free from unnecessary medications; Resident #309. The facility staff failed to provide non-pharmacological interventions to Resident #309 prior to the administration of prn (as needed) Xanax (1) and failed to document if Xanax was effective on 7/29/16, 7/30/16 and 7/31/16. The findings include: Resident #309 was admitted to the facility on 9/22/2009 with diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease, Osteoarthritis, high blood pressure,	{F 329}	documentation prior to and after medication administration to include effectiveness. Random weekly review will be conducted by the DCS/designee for five (5) residents per week for three (3) months to ensure that the non-pharmacological interventions have been attempted prior to medication administration and that effectiveness of intervention has been documented. 4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months and then quarterly. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. 5. 8-22-16	

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bipolar disorder, anxiety disorder, paranoid schizophrenia, and narcissistic personality disorder.

Resident 309's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (assessment reference date) of 5/27/16. Resident #309 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #309 was coded as requiring supervision with most ADLS (Activities of Daily Living).

Review of Resident #309's POS (Physician Order Sheet) dated 7/31/16, documented the following order: "ALPRAZOLAM 1MG (milligram) TABLET (XANAX) Take 1 tab (tablet) by mouth every 8 hours as needed."

Review of Resident #309's care plan documented the following under care area Behavior/Mood: "Anti-anxiety: Non-drug interventions-see behavior management care plan." Review of the behavior management care plan dated 5/26/15 documented the following interventions: "Introduce self when providing care, explain procedures to resident before providing care, assess behaviors for underlying medical causes, assess resident for pain as indicated, psychological consult as needed, medications per physician orders, Invite and assist as needed to activities of choice, encourage resident to attend group activities, Redirect inappropriate behaviors as needed..."

Review of Resident #309's July 2016 MAR (Medication Administration record) documented that Resident #309 received Xanax prn (as

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needed) on the following dates and times:

7/28/16 at 10 a.m.
7/29/16 at 9 a.m.
7/30/16 at 9 a.m.
7/31/16 at 9 a.m.
7/31/16 at 9:50 p.m.

Review of the nursing notes revealed no documentation that non-pharmacological interventions were attempted prior to the administration of Xanax on the above dates.

On 7/29/16 through 7/31/16 there was no documentation as to why the Xanax was administered and if it was effective.

On 8/3/16 at 10:10 a.m., an interview was conducted with LPN (licensed practical nurse) #2, regarding the process staff follow prior to administering prn (as needed) psychoactive medication. LPN #2 stated that he would try to re-direct the resident first and try non-pharmacological interventions before administering medication. He stated that he would document these interventions. LPN #2 stated, "I would document just so it didn't look like I was just medicating him." LPN #2 reviewed Resident #309's MARs and nursing notes and confirmed that he did not see non-pharmacological interventions attempted prior to administering the Xanax. LPN #2 also stated he did not see documentation as to why Xanax was administered on 7/29/16, 7/30/16 and 7/31/16. LPN #2 confirmed that there was no documentation that the Xanax had been effective.

On 8/3/16 at 11:00 a.m., an interview was conducted with LPN #4, regarding the process

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staff follow prior to administering prn {as needed) psychoactive medication. LPN #4 stated that she would attempt other things prior to administering medications. LPN #4 stated that she would offer snacks, drinks etc. and document that she attempted non-pharmacological interventions. LPN #4 stated she could not find evidence that non-pharmacological interventions were put into place prior to the administration of the Xanax. LPN #4 could not find evidence of documentation showing why Resident #309 had received the Xanax on 7/29/16, 7/30/16 and 7/31/16. LPN #4 stated, "He doesn't usually get Xanax for me but I heard that he asks for it." LPN #2 stated that nursing should have attempted to offer the resident alternatives to decrease his anxiety prior to administering Xanax. LPN #4 also stated that a note should be created documenting attempts.

On 8/3/16 at 2:35 p.m., ASM #1, the Executive Director, ASM #2, the Director of Clinical Services, ASM #3, the Assistant Director of Clinical Services, and ASM #4, the Regional Director of Clinical Services were made aware of the above findings.

The facility Policy titled, "Psychoactive Medications" documents in part, the following: "...7. Non-Pharmacological Interventions will be used to avoid using psycho-pharmacological drugs to the extent possible."

According to Fundamentals of Nursing, 5th edition, Craven and Hirnle, Lippincott, Williams & Wilkins, page 565, "Nurses also are responsible for documenting the therapeutic effects and side effects of any medication administered."

(1) Xanax- used to relief symptoms of anxiety

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including anxiety caused by depression. It is also used to treat panic disorder in some patients. This information was obtained from The National Institutes of Health. http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/?report=details.

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{F 514} SS=E 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to maintain a complete and accurate clinical record for three of 16 residents in the survey sample, Residents # 307, # 314, and # 316.

1. For Resident # 307 the facility staff failed to document that medications were administered on 7/29/16 at 5:00 p.m.

2. The facility staff failed to document pain

{F 514}

F 514

1. Resident #307 is receiving medications as per Physician order. Resident #314 has a documented pain assessment as per Physician order. Resident #316 has abdominal binder in place and a skin check has been completed as ordered.
2. Residents that reside in the facility have the potential to be affected by failure to document completion of medication administration, pain

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assessment that was ordered by the physician on several occasions in July of 2016 for Resident # 314.

3. The facility staff failed to document that an abdominal binder was in place and skin checks were provided on 7/29/16 and 8/1/16 for Resident # 316.

The findings include:

1. Resident # 307 was admitted to the facility on 10/26/12 and readmitted on 1/23/13 with diagnoses that included but were not limited to: anemia, hypertension, hyperlipidemia, seizure disorder, diabetes, depression, chronic obstructive pulmonary disease, abdominal aortic aneurysm, atrial fibrillation, and glaucoma.

The most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 6/9/16 coded Resident # 307 as usually understood by others and usually able to understand others. Resident # 307 was coded as scoring 7 out 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was cognitively impaired.

Review of the clinical record revealed physician orders for the following:

A physician ordered dated 1/17/14 and most recently signed by the physician on 7/30/16: "POLYETHYLENE GLYCOL ...FOR MIRALAX (1) MIX 17 GM (grams) (1 CAPFUL) IN 8OZ (ounces) OF WATER OR JUICE AND TAKE BY MOUTH TWICE DAILY (9AM & 5 PM) (9:00 a.m.

assessments, skin checks and placement of abdominal binders.
3. Licensed Nursing staff has been educated on following Physician orders for medication administration, following treatment orders, and accurate and complete documentation. Licensed Nursing staff has also completed a medication administration course. MARs/TARs will be audited daily x3 months then weekly x 3 months by DCS/designee to ensure that medications are being administered as per Physician order and treatments have been executed as per Physician order, to include abdominal binders and skin checks

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& 5:00 p.m.)."

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "SENOKOT (2)...2 TABLETS BY MOUTH TWICE DAILY (9AM & 5PM)."

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "SODIUM BICARBONATE (3) 650 MG (milligrams) TABLET 1 TAB (tablet) BY MOUTH TWICE DAILY (9AM & 5PM)."

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "GABAPENTIN (4) 300 MG 1 CAP (capsule) BY MOUTH THREE TIMES DAILY (9AM, 1PM, & 5PM)."

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "MEXILETINE HCL (5) 150 MG CAPSULE 1 CAP BY MOUTH THREE TIMES DAILY (9AM, 1PM, & 5PM)."

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "MIDODRINE HCL (6) 5 MG TABLET 1 TAB BY MOUTH THREE TIMES DAILY (9AM, 1PM, & 5PM)."

A physician ordered dated 2/24/13 and most recently signed by the physician on 7/30/16: "LEVETIRACETAM (7) 500 MG TABLET...1 TAB (tablet) BY MOUTH TWICE DAILY (9AM & 5PM)."

Review of the MAR (medication administration record) for 7/29/16 at 5:00 p.m. revealed that

4. Results of the reviews will be discussed by the administrator/designee at the Quality Assurance Performance Improvement meeting monthly for three (3) months and then quarterly. The committee will recommend provisions to the plan as indicated to sustain substantial compliance.
5. 8-22-16

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there was no documentation that the above medications were administered.

During an interview on 8/3/16 at 9:20 a.m. with LPN (licensed practical nurse) # 1 when asked about blanks on the MAR, LPN # 1 stated that blanks mean that staff did not sign out the medication - not signing out looks like the medication was not given but does not mean that it was not given.

During an interview on 8/3/16 at 10:10 a.m. with LPN # 2, LPN # 2 was asked what it means if there is a blank on the MAR. LPN # 2 stated, "It either means the nurse forgot to document or did not give the medication, I really don't know - probably just forgot to document."

During an interview on 8/3/16 at 10:50 a.m. with LPN # 4, LPN # 4 was asked what blanks on the MAR mean. LPN # 4 stated that in school we are taught that if it is not documented then it is not given but staff can miss signing off and one would not know unless the individual nurse was asked.

During an interview on 8/3/16 at 11:17 a.m. with LPN # 5, LPN # 5 was asked what blanks on the MAR mean. LPN # 5 stated that a blank means it was not done but it could mean they (nurse) just forgot to sign and that the medication was given.

An interview was conducted on 8/3/16 at 11:45 a.m. with LPN # 10 the LPN assigned to Resident # 307 on 7/29/16 and who was responsible for administering the Resident's medications. LPN # 10 stated, "I know I gave the medications, I don't know why I didn't sign them off but I did give them. I may have gotten distracted by another resident, but I know I gave them."

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During an interview on 8/3/16 at 2:25 p.m. with ASM (administrative staff member) # 1, the executive director, ASM # 2, the director of clinical services, and ASM # 3, the regional director of clinical services, this concern was shared and a copy of the facility policy was requested.

Review of the facility policy: "Clinical/Medical Records" under "Policy:...Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care..."

No further information was provided prior to exit.

According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."

(1) MIRALAX (Polyethylene glycol) is used to treat occasional constipation. Polyethylene glycol is in a class of medications called osmotic laxatives. It works by causing water to be retained

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with the stool. This increases the number of bowel movements and softens the stool so it is easier to pass. https://medlineplus.gov/druginfo/meds/a603032.html

(2) SENOKOT (Senna) is used on a short-term basis to treat constipation. It also is used to empty the bowels before surgery and certain medical procedures. Senna is in a class of medications called stimulant laxatives. It works by increasing activity of the intestines to cause a bowel movement. https://medlineplus.gov/druginfo/meds/a601112.html#why

(3) SODIUM BICARBONATE is an antacid used to relieve heartburn and acid indigestion. Your doctor also may prescribe sodium bicarbonate to make your blood or urine less acidic in certain conditions. https://medlineplus.gov/druginfo/meds/a682001.html

(4) GABAPENTIN capsules, tablets, and oral solution are used to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). Gabapentin extended-release tablets (Horizant) are used to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Gabapentin is in a class of medications called anticonvulsants. Gabapentin treats seizures by decreasing abnormal

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excitement in the brain. Gabapentin relieves the pain of PHN by changing the way the body senses pain. It is not known exactly how gabapentin works to treat restless legs syndrome. https://medlineplus.gov/druginfo/meds/a694007.html

(5) MEXILETINE is used to treat certain types of ventricular arrhythmias (abnormal heart rhythms). Mexiletine is in a class of medications called antiarrhythmics. It works by blocking certain electrical signals in the heart to stabilize the heart rhythm. https://medlineplus.gov/druginfo/meds/a607064.html

(6) MIDODRINE may cause supine hypertension (high blood pressure that occurs when lying flat on your back). This medication should only be used by people whose low blood pressure severely limits their ability to perform daily activities and who could not be treated successfully with other therapies. Tell your doctor if you have or have ever had high blood pressure. Tell your doctor and pharmacist if you are taking dihydroergotamine (DHE, Migranal). Also tell your doctor and pharmacist what other prescription and nonprescription medications you are taking, including ephedrine, phenylephrine, phenylpropanolamine, and pseudoephedrine. Many nonprescription products contain these medications (e.g. diet pills and medications for cough and colds), so check labels carefully. If you experience any of the following symptoms, stop taking midodrine and call your doctor immediately: awareness of your heartbeat, pounding in your ears, headache, or blurred vision. https://medlineplus.gov/druginfo/meds/a616030.h

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(7) LEVETIRACETAM in a class of medications called anticonvulsants. It works by decreasing abnormal excitement in the brain. https://medlineplus.gov/druginfo/meds/a699059.html

2. The facility staff failed to document pain assessment that was ordered by the physician on several occasions in July of 2016 for Resident #314.

Resident #314 was admitted to the facility on 4/17/15 with diagnoses that included but were not limited to osteoarthritis, diabetes mellitus type 2, chronic pain syndrome, high blood pressure, Alzheimer's disease, and unspecified dementia. Resident #314's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/1/16. Resident #314 was coded as being severely impaired in cognition, scoring three out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #314 was coded as requiring supervision with most ADLS (Activities of Daily Living) and extensive assistance with bathing.
Review of Resident #314's July 2016 POS (Physician Order Sheet) documented the following order: "Indicate Pain Status/Rating: (0-10) chart every shift." This order was signed by the physician on 7/19/16.
Review of Resident #314's July 2016 MAR revealed no signatures documented on the following dates and shifts for pain monitoring:
7/29/16 11-7 shift
7/30/16 3-11 shift
7/30/16 11-7 shift
7/31/16 11-7 shift

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Review of Resident #314's July 2016 nursing notes for the above dates revealed no documentation of a pain assessment.
On 8/3/16 at 10:13 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. When asked what blanks (No signatures) meant on the MAR, LPN #2 stated either the pain assessment was not completed or the nurse on shift forgot to sign. LPN #2 stated, "With the pain assessment, the nurse probably forgot to document because we do a pain assessment every shift when we see the resident."
On 8/3/16 at 10:35 a.m., an interview was conducted with LPN #4. When asked what blanks meant on the MAR, LPN #4 stated that either the medication or task was not completed or the nurse forgot to sign. LPN #4 stated that nurses can sometimes miss documenting.
When asked how she would know if the nurse prior to her completed a certain task or administered a medication, LPN #4 stated, "Well we are supposed to check over the MARS with the oncoming nurse at change of shift to make sure there are no holes (blanks) in the MAR."
On 8/3/16 at 2:35 p.m., ASM #1, the Executive Director, ASM #2, the Director of Clinical Services, ASM #3, the Assistant Director of Clinical Services, and ASM #4, the Regional Director of Clinical Services were made aware of the above findings.
Facility Policy titled, "Medical/Clinical Records" documented the following: "Clinical records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care."
No further information was presented prior to exit.

The following quotation is found in Potter and

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Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

3. Facility staff failed to document that an abdominal binder was in place and skin checks were provided on 7/29/16 and 8/1/16 for Resident #316.
Resident # 316 was admitted to the facility on 6/8/16 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), muscle weakness, heart failure, high blood pressure and chronic respiratory failure.
Resident #316's most recent MDS (Minimum Data Set) was a five day scheduled assessment with an ARD (Assessment Reference Date) of 7/29/16. Resident #316's was coded as being severely cognitively impaired in the ability to make daily decisions scoring three on the staff assessment for mental status exam. Resident #316 was coded as requiring extensive assistance to being dependent on staff with ADLS (Activities of Daily Living). The resident was coded as having a peg tube.
On 7/22/16 the following physician order was documented, "Abdominal Binder check placement and skin qs (every shift) and prn (as needed)..."
Review of the July 2016 MAR revealed that on July 29th, 30th, and 31st 2016, the MAR was left

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blank for 7-3, 3-11 and 11-7 shift for the Abdominal binder order.

On August 1st, for 11-7 and 7-3 shift, the MAR was left blank for the Abdominal Binder order.

On 8/3/16 at 10:35 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked what blanks meant on the MAR, LPN #4 stated that either the medication or task was not completed or the nurse forgot to sign. LPN #4 stated that nurses can sometimes miss documenting. When asked how she would know if the nurse prior to her completed a certain task or administered a medication, LPN #4 stated, "Well we are supposed to check over the MARS with the oncoming nurse at change of shift to make sure there are no holes (blanks) in the MAR."

On 8/3/16 at 10:45 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #7, the nurse who worked the weekend on July 30th through the 31st 2016. When asked what blanks meant on the MAR she stated the nurse may have forgotten to sign the MAR or the treatment or medication was not administered. LPN #7 stated that she had worked on 7/30 and 7/31 7-3 and 3-11 shift. When asked if she had Resident #316, she stated that she did. When asked if he had his abdominal binder in place she stated that she was not sure about Saturday but she knew on Sunday he did not have one in place. When asked why he did not have his abdominal binder in place, LPN #7 stated, "I didn't think we were putting it on him because he had a peg tube infection." When asked if she had documented anywhere that she did not place the binder on due to an infection, LPN #7 stated that

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she did not. When asked if there was an order to hold the abdominal binder until the infection healed, LPN #7 stated that she could not remember. She was not one of the nurses who worked 7/29/16 or 8/1/16.

On 8/3/16 at 11:50 a.m., an interview was conducted with LPN #8. She stated that had worked on August 1st on 11-7 shift. She stated that the abdominal binder was in place during her shift.

The other nurses could not be reached for an interview.

On 8/3/16 at 2:35 p.m., ASM #1, the Executive Director, ASM #2, the Director of Clinical Services, ASM #3, the Assistant Director of Clinical Services, and ASM #4, the Regional Director of Clinical Services were made aware of the above findings.

No further information was presented prior to exit.